State of Wisconsin
Health Insurance Risk Sharing Plan (HIRSP)

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Amendment to the Policy of the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) Regarding Care Management Program

Effective April 1, 2005, the Wisconsin Health Insurance Risk Sharing Plan (HIRSP) is amending your HIRSP policy to include a care management program.

This amendment contains only information regarding these care management program provisions. For full details about your HIRSP coverage, always refer to your HIRSP policy as well as any amendments.

The following sections are added to your HIRSP policy:

1. Part Y. Care Management Program is added as follows:

PART Y. Care Management Program

The HIRSP coverage has a care management program. Please read this section very carefully. If you do not follow the procedures described below, benefits for health care services you incur may not be covered under the HIRSP policy if those health care services are determined to be not ***medically necessary*** or ***experimental*** or investigative in nature.

(1) ***Hospital*** **Admission Authorization**

(a) **Non-*Emergency Hospital* Admission.**

A ***policyholder,*** or their family member, physician, ***hospital*** or other health care ***provider*** acting on behalf of the ***policyholder*** should notify the plan administrator at least three business days before the ***policyholder*** is admitted to a ***hospital*** for non-***emergency*** care. This starts the process of ***hospital*** admission review. The plan administrator will authorize the ***policyholder's*** admission if it is ***medically necessary***, or deny it if it is not ***medically necessary***.

(b) ***Hospital Emergency*** **Admission.**

A ***policyholder,*** or their family member, ***physician***, ***hospital*** or other health care ***provider*** acting on behalf of the ***policyholder*** should notify the plan administrator within two business days of the ***policyholder's hospital*** admission for ***emergency*** care. The plan administrator will authorize the ***policyholder's*** admission if it is ***medically necessary***, or deny it if it is not ***medically necessary***.

(2) Prenatal and Maternity Care Notification

If a ***policyholder*** is pregnant, the plan administrator requests that the plan administrator be notified:

(a) after the ***policyholder's*** first prenatal visit; and

(b) within 24 hours or the first business day following the date of the ***policyholder's*** delivery.

Although the ***policyholder's*** failure to provide such notice won't reduce benefits otherwise payable for such health care services, notice to the plan administrator will allow the plan administrator to work with the ***policyholder*** and their ***physician*** during the ***policyholder's*** pregnancy to help coordinate ***medically necessary*** health care services and provide high-risk screening and health information.

(3) Individual Case Management

(a) Alternate Treatment.

From time to time the plan administrator may, at its option, suggest that the ***policyholder*** consider an alternate treatment for their covered illness or injury which differs from their current treatment of that illness or injury if it appears that the alternative treatment is not subject to an exclusion of the policy and:

- the alternate treatment offers a medical therapeutic value at least equal to the current treatment;

- the current treatment may be changed without jeopardizing the ***policyholder's*** health; and

- the charges incurred for services to be provided under the alternate treatment to its end will probably be less than those charges to be incurred for services to be provided under the current treatment.

The plan administrator will contact the ***policyholder's*** attending ***physician*** to: (1) suggest consideration of the alternate treatment; (2) advise the ***physician*** of the possible benefits payable by the plan administrator for charges for such treatment; and (3) answer any questions the attending ***physician*** may have.

The plan administrator will then send a letter to both the ***policyholder*** (or their authorized representative) and the attending ***physician***. That letter will provide a description of the alternate treatment and an estimate of the possible benefits payable by the plan administrator for the charges to be incurred for such treatment.

If the ***policyholder*** or their authorized representative and the attending ***physician*** agree to the alternate treatment, the letter must be signed by the ***policyholder*** or their authorized representative and the ***policyholder's*** attending ***physician***. The signed letter must be promptly returned to the plan administrator. The alternate treatment must begin as soon as reasonably possible. If the ***policyholder*** or their authorized representative and/or the attending ***physician*** do not agree with the alternate treatment, benefits for charges incurred for the current treatment remain payable as provided under the policy. Acceptance of the alternate treatment does not prevent a change in treatment at any time thereafter.

(b) Alternate Confinement

From time to time the plan administrator may, at its option, suggest that the ***policyholder,*** while confined in a ***hospital*** for a covered illness or injury, consider a transfer to another institution if it appears that the alternative confinement is not subject to an exclusion of the policy and:

- the other institution can provide the necessary medical care;

- the physical transfer would not jeopardize the ***policyholder's*** health and the medical effectiveness of the current confinement; and

- the charges to be incurred for the alternate confinement at the other institution will probably be less than those charges to be incurred for continued confinement at the current hospital.

The plan administrator will contact the ***policyholder's*** attending ***physician*** to: (1) suggest consideration of the alternate confinement; (2) advise the ***physician*** of the possible benefits payable by the plan administrator for charges for such confinement; and (3) answer any questions the attending ***physician*** may have.

The plan administrator will then send a letter to both the ***policyholder*** (or their authorized representative) and the attending physician. That letter will provide a description of the alternate confinement and an estimate of the possible benefits payable by the plan administrator for the charges to be incurred for such confinement.

If the ***policyholder*** or their authorized representative and the attending ***physician*** agree to the alternate confinement, the letter must be signed by the ***policyholder*** or their authorized representative and the ***policyholder's*** attending ***physician***. The signed letter must be promptly returned to the plan administrator. The alternate confinement must begin as soon as reasonably possible. If the ***policyholder*** or

their authorized representative and/or the attending ***physician*** do not agree with the alternate confinement, benefits for charges incurred for the current confinement remain payable as provided under the policy. Acceptance of the alternate confinement does not prevent a change in confinement at any time thereafter.

(4) Disease Management Programs

Policyholders who are pregnant or who have chronic health conditions may benefit from the plan administrator's programs that can help them manage their conditions including:

(a) diabetes;

(b) heart and lung diseases (coronary artery disease and congestive heart failure);

(c) asthma (adult and pediatric);

(d) renal disease;

(e) depression; and

(f) alcohol and substance abuse.

The plan administrator's disease management programs offer one-on-one counseling and/or disease education. At the heart of this patient-focused, personalized approach is a team of experienced nurses, social workers, and an alcohol and substance abuse counselor, whose ongoing support:

(a) empowers the ***policyholder*** to take a more active role in their own disease management therapy through the plan administrator's education programs and communication materials;

(b) improves compliance with prescribed therapies;

(c) enhances both clinical and medical resource outcomes.

Under the HIRSP policy, potential disease management ***policyholder*** candidates are identified through the plan administrator's claims processing system by diagnosis codes or by a referral from a family member, health care ***provider*** or HIRSP staff. To learn more about the plan administrator's disease management programs, please call 866-841-6572 and ask to speak to a disease manager.

2. Part Z. Preauthorization is added as follows:

PART Z. PREAUTHORIZATION PROCEDURE

If a ***policyholder*** wants to submit what we call a "preauthorization" request to the plan administrator, the ***policyholder*** can ask the plan administrator whether or not a health care service will be covered under the policy.

The plan administrator does not pay benefits for health care services that are ***experimental***, investigative or not ***medically necessary*** or excluded from coverage due to an exclusion, as determined by the plan administrator. The types of health care services that may fall into this category, but not limited to these, are:

(1) Transplants and implants of body organs, except as specifically stated in the policy;

(2) New medical or biomedical technology;

(3) New surgical methods or techniques;

(4) Sleep studies;

(5) Gastrointestinal surgery for obesity;

(6) Sclerotherapy;

(7) Dialysis treatment and kidney transplant services;

(8) Intravenous therapy performed in your home;

(9) Home care and hospice care;

(10) Prosthetics costing more than $1,000;

(11) Durable medical equipment costing more than $500;

(12) Pain management procedures as follows: (a) intradiscal electro therapy (IDET); (b) radiofrequency neuroablation (neurolysis) of the facet joint nerves; (c) facet joint injections; (d) trigger point injections; (e) epidural injections, other than epidural injections provided to the pregnant ***policyholder*** in connection with labor or delivery of a newborn child or due to surgery; and (f) medial branch nerve blocks and sacroiliac joint injections.

After the plan administrator receives a preauthorization request, the plan administrator will make a determination on whether or not to pre-authorize benefits for the health care service based upon the information available to the plan administrator at the time the plan administrator receives the preauthorization request. The plan administrator will send the ***policyholder*** its written response to the preauthorization request, telling the ***policyholder*** whether the health care service is covered.

However, even if a health care service is preauthorized in writing by the plan administrator, no benefits will be paid unless after receiving the proof of claim, the plan administrator determines that benefits are payable for that preauthorized health care service under the terms, conditions, exclusions, limitations, and all other provisions of the policy and the ***policyholder's*** coverage is in effect at the time the health care service is provided to the ***policyholder*** and the health care services are provided by a HIRSP-certified ***provider***. Even if a health care service is preauthorized by the plan administrator under this section and provided by a HIRSP-certified ***provider***, benefits are still subject to all terms, conditions and provisions of the policy.

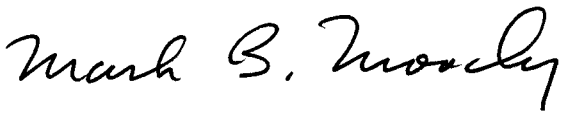
The proof of claim may differ from the preauthorization request. This means that the plan administrator's preauthorization of benefits is not its final decision and does not guarantee our payment of benefits later. This means that benefits may not be paid if, after reviewing the proof of claim, the plan administrator determines that the health care service is not covered under the policy.

If the ***policyholder*** or their ***physician*** disagrees with the plan administrator's decision, the ***policyholder*** may request a review in accordance with the provisions in Part W. Review and Grievance Process.

This amendment shall be effective April 1, 2005. It shall continue in force under the same terms, conditions, and provisions as govern the policy and any amendments.

All other terms, conditions, and provisions of the policy remain unchanged except as stated above.

This amendment is signed for HIRSP by



Mark Moody
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